***Applicant Must Complete***

| CON Number |
|---|
| Facility Number |
| Date Submitted |

**AMENDMENT REQUEST for CERTIFICATE OF NEED**

**Michigan Department of Health & Human Services**

**CERTIFICATE OF NEED**

South Grand Building, 4th Floor
P.O. Box 30195
Lansing, Michigan 48909

Phone: (517) 241-3344 – Fax: (517) 241-2962

| **CON OFFICE ONLY** |
|---|
| Amendment Fee |
| Amount: |
| Received: |

| | |
|---|---|
| **AUTHORITY:** PA 368 of 1978, as amended<br>**COMPLETION:** Is **Voluntary**, but is required to obtain a Certificate of Need. If NOT completed, a Certificate of Need will NOT be issued. | The Department of Health & Human Services is an equal opportunity employer, services, and programs provider. |

## SECTION 1 - Facility Information

| Current/Proposed Facility Name | | | Area Code and Telephone Number Extension |
|---|---|---|---|
| Facility Street Address | | | County |
| City | State | ZIP Code | Applicant's Federal ID |

## SECTION 2 - Applicant Organization

| Legal Name of Applicant Organization (Include assumed name applicable to this project) | |
|---|---|
| Area Code, Telephone No. & Ext. | FAX No. (Area Code and No.) |
| Street Address | |
| City / State / ZIP Code | |
| Email (administrator): | |

## SECTION 3 - Agent Information

| Authorized Agent Name | |
|---|---|
| Authorized Agent Organization | |
| Area Code, Telephone No. & Ext. | FAX No. (Area Code and No.) |
| Street Address | |
| City / State / ZIP Code | |
| Email: | |

## SECTION 4 - Justification for Amendment Request: *(Attach additional sheets as necessary)*

**SECTION 5 – Amended Project Description:** *(Attach additional sheets as necessary)*
*Note*: Use "Project Description" in original CON approval letter or last approved Amendment letter, which ever is most current. Amended Project Description should reflect changes requested in proposed amendment.

**SECTION 6 – Projected Completion Date**

| Projected Completion Date in Application or last approved Amendment | New Projected Completion Date |
|---|---|
| | |

## SECTION 7 – Project Costs

| Are project costs changing as a result of this amendment? ☐ NO ☐ YES | Provide changes in format below using most recent CON approval letter including all project costs. | | |
|---|---|---|---|
| **Line Item Description** | **Approved** | **Amended** | **+ / - Difference** |
| 1. New Construction - Clinical ( sq. ft.) | $ | $ | $ |
| 2. New Construction – Non Clinical ( sq. ft.) | $ | $ | $ |
| 3. Renovation and Remodeling - Clinical ( sq. ft.) | $ | $ | $ |
| 4. Renovation and Remodeling – Non Clinical ( sq. ft.) | $ | $ | $ |
| 5. Architect/Engineering Fees | $ | $ | $ |
| 6. Contingencies | $ | $ | $ |
| 7. Feasibility Study/Surveys | $ | $ | $ |
| 8. Site Preparation | $ | $ | $ |
| 9. Fixed Medical Equipment | $ | $ | $ |
| 10. Fixed Non-Medical Equipment | $ | $ | $ |
| 11. Covered Clinical Equip (PET, MRI, etc.) – Lease term (if applicable) | $ | $ | $ |
| 12. Movable Equipment (Medical and Non-Medical) | $ | $ | $ |
| 13. Fees (Consulting, Legal, Banking, etc.) | $ | $ | $ |
| 14. Space Lease Cost – Term: | $ | $ | $ |
| 15. Land Purchase | $ | $ | $ |
| 16. Building Purchase | $ | $ | $ |
| 17. Interest During Construction | $ | $ | $ |
| 18. Other *(explain):* | $ | $ | $ |
| 19. Other *(explain):* | $ | $ | $ |
| 20. Other *(explain):* | $ | $ | $ |
| **TOTALS** | $ | $ | $ |

## SECTION 8 – Sources of Funds

| Are sources of funds changing as a result of this amendment? ☐ NO ☐ YES | Provide changes in format below using most recent CON approval letter including all sources of funds. | | |
|---|---|---|---|
| **Line Item Description** | **Approved** | **Amended** | **+ / - Difference** |
| 1. Unrestricted Cash | $ | $ | $ |
| 2. Designated Funds | $ | $ | $ |
| 3. Restricted Funds | $ | $ | $ |
| 4. Mortgages/Loans (FHA, HUD, etc.) | $ | $ | $ |
| 5. Bond Issue | $ | $ | $ |
| 6. Other Funds (i.e., grants, etc.) | $ | $ | $ |
| 7. Capital/Operating Lease | $ | $ | $ |
| 8. Gifts, Bequests, Donations, and Pledges | $ | $ | $ |
| 9. Interest Income During Construction | $ | $ | $ |
| 10. Other *(explain):* | $ | $ | $ |
| 11. Other *(explain):* | $ | $ | $ |
| **TOTALS** | $ | $ | $ |

## COST PER SQUARE FOOT CALCULATIONS:

New Construction: ($ / sq. ft. = $ per sq. ft.)

Renovation & Remodeling: ($ / sq. ft. = $ per sq. ft.)

Note: Please combine Clinical & Non-Clinical Costs and areas in calculation.

### SECTION 9 – Document Request:

An Amendment request shall not be considered submitted to the Department until the following documents are received, as applicable:

- A copy of audited financial statements if Project Costs or Sources of Funds have changed from the approved project. If audited financial statements are not available, provide unaudited current financial statements including a balance sheet, income statement, statement of cash flows and any notes to accompany the financial statements. New entities must provide a current balance sheet, a projected income statement for the first year of operations, a projected statement of cash flows for the first year of operations, and any notes to accompany the financial statements.
- Revised site and floor plans if changed from the approved project.
- New signed and dated vendor quotes if changed from the approved covered clinical equipment.
- Email all electronic forms and documents to MDHHS-CONProjects@Michigan.gov

### SECTION 10 – Notification:

The new Certificate of Need (CON) fee bill (Public Act 137) was signed by the Governor on October 15, 2013, and is effective.

MCL 2016(3)(d): The department shall charge a fee of $500 to review any letter of intent requesting or resulting in a waiver from Certificate of Need review and any amendment request to an approved Certificate of Need.

**Amendment fee ($500) must be submitted at the same time as this request per MCL 20161(3)(d). The amendment request will not be deemed received until the appropriate fee has been received at the Cashiers office, address listed below. Once the amendment fee is received by the Cashiers office the amendment will be processed, as required by the administrative rules.**

**Only CON payments (checks) must be mailed to:**

**MDHHS CASHIER OFFICE SUITE 801**
**CERTIFICATE OF NEED**
**P.O. BOX 30437**
**LANSING, MI 48933**

**All CON amendments and documents must be mailed to:**

**PROJECT REVIEW COORDINATOR**
**CERTIFICATE OF NEED**
**MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES**
**SOUTH GRAND BUILDING, 4TH FLOOR**
**P.O. BOX 30195**
**LANSING, MI 48909**